STATEMENT OF
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Good Afternoon, Mr. Chairman and members of the Subcommittee. Thank you for the opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to provide safe, effective, efficient and compassionate health care to veterans residing in rural areas.

In fiscal year 2006, the Department of Veterans Affairs (VA) served about 5.4 million patients. Approximately 39 percent of these veterans resided in rural areas and another 2 percent resided in highly rural areas[1]. VA is fulfilling its mission by providing the highest quality of care to all veterans and understands that although veterans in rural areas face many of the same health concerns as veterans in urban areas, rural area veterans often face additional and unique challenges such as limited finances and fewer specialists. The primary challenge in serving veterans who reside in rural areas is to effectively address access to quality care in areas where veteran populations are usually widely distributed over a large geographical area.

The VA has undergone a profound transformation in the delivery of health care over the last decade. VA has moved from a hospital driven health care system to an integrated delivery system that emphasizes a full continuum of care. New technology and treatment modalities have changed how and where care is provided with a significant shift from inpatient to outpatient and in-home services. Throughout that transformation, VA has considered our veterans who live in rural areas and how best the VA can enhance their access to the quality health services that we strive to provide to all veterans.

VA's comprehensive approach for providing care to veterans residing in rural areas has proven successful. We are setting the industry standards for using advanced technology with our telehealth healthcare delivery programs. With this advanced technology, we are providing services directly to veterans in their homes and expanding specialized care in our Community-Based Outpatient Clinics (CBOCs) through telemedicine capabilities. We have been successful in creating greater access to

[1] Definitions: Urban – areas defined by U.S. Census as urbanized areas; Rural – all other areas excluded in U.S. Census defined urbanized areas; Highly Rural – any rural area within a county with less than 7.0 civilians per square mile

quality services though expansion of CBOCs. Over 92 percent of enrollees reside within one hour of a VA facility, and 98.5 percent are within 90 minutes.

Our veterans tell us that they are satisfied with the services and high quality care we are providing to them. This is substantiated by their high satisfaction reporting, with veterans in rural areas reporting comparable satisfaction to their urban counterparts.

I share the Committee's concern for these veterans and would like to take a few minutes to discuss our strategic direction and current programs that will reveal how VA is moving towards a comprehensive plan with initiatives to address rural veterans' issues.

RURAL HEALTH INITIATIVES

The strategic direction for providing services to veterans residing in rural areas is to provide non-institutionalized care; to bring care into veterans' homes. Examples of this are telehealth, mail pharmacies, and home based primary care. If it is not possible to provide services in the home, veterans will come to one of the many access points that VA has established. VA has systematically undertaken a number of efforts aimed at addressing delivery of health care services to veterans who reside in rural areas. Central to these efforts are several major initiatives now being implemented throughout the VA system: establishing an Office of Rural Health to focus attention on issues of veterans who reside in rural areas; our telehealth and telemedicine programs, which are using new technology to bring healthcare providers to their patients, rather than patients to their healthcare providers; establishment of CBOCs to increase access to care; and utilization of fee-based service with private health care providers. I will now discuss these efforts and others in greater detail while providing information on key health concerns facing many of our veterans.

VHA's OFFICE OF RURAL HEALTH

VHA is focusing attention on the special needs of veterans who reside in rural areas. In accordance with Section 212 of the Public Law 109-461, VHA is establishing an Office of Rural Health. The mission of the office is to promulgate policies, best practices and innovations to improve services to veterans who reside in rural areas of the United States.

TELEHEALTH – IMPACTS ON RURAL CARE

VA is an acknowledged national leader in the development of telehealth. VA's telehealth programs have reached a size and complexity that are unparalleled elsewhere. VA continues to implement telehealth through further expansion of its care coordination/telehealth programs. This approach embeds telehealth within an appropriate, effective and cost-effective clinical environment. Consequently, access to care is expanding and enabling convenience in how veteran patients receive services to

become a predominant consideration, one that fits with the overarching mission for these programs of providing the right care at the right time in the right setting.

For veteran patients with chronic disease, when it is appropriate and their choice, the preferred setting for care is the home. Care coordination/home telehealth programs (CCHT) are well established in all 21 Veterans Integrated Service Networks (VISNs) and currently care for 24,921 patients. This patient census (point prevalence figure) already represents a 25 percent increase over fiscal year 2006 numbers and places VA on target to meet a projected growth in the program of 50 percent by the end of fiscal year 2007. CCHT supports patients with chronic conditions such as diabetes, chronic heart failure, chronic obstructive pulmonary disease, post-traumatic stress disorder, and depression to remain living independently in their own homes. The program design is such that care can be delivered remotely from VA Medical Centers and 25 percent of CCHT patients are in rural areas and another 1 percent is in highly rural areas.

The next phase of expansion in CCHT programs and ongoing extension into rural areas involves VA's implementation of a home telemental health initiative that will support veterans with PTSD and those who need treatment for substance abuse to be managed at home. These new CCHT home telemental health services are intended to support the care of an additional 2,000 veterans by the end of fiscal year 2008. VA anticipates that such services will initially develop and thereafter further expand in the same geographic locations as existing CCHT programs. VA is currently working on telecommunications strategies to facilitate the provision of CCHT services in rural areas, thus improving access to care for veteran patients and reducing their need to travel for services. Since January 2004, VHA has trained over 3,500 staff nationally to provide care via CCHT. This training is done via distance learning techniques to enhance service development and ensure their sustainability in rural and remote areas.

In fiscal year 2006, over 19,000 unique veteran patients received care in CBOCs and outlying VA Medical Centers via telemental health. Already, in the first quarter of fiscal year 2007, over 8,000 patients have received care via telemental health. Current projections are that VA will provide care in this manner to over 30,000 veterans during fiscal year 2007.

The VA’s Rocky Mountain Telehealth Training Center is focusing on making distance learning available to the providers in rural areas who are providing services via telehealth. Additionally, the VA readjustment counseling program (Vet Centers) is currently working on a strategy to expand services in rural areas by further expansion of its telehealth capacity.

VHA has now implemented its national teleretinal imaging program to screen veteran patients with diabetes for diabetic eye disease. This program was instituted at a total of 159 image acquisition sites over the past 18 months. This implementation represents a 60 percent increase over that which was originally planned. Currently 50 percent of these image acquisition sites are in rural areas. Overall the program has provided services to 18,000 patients with a projected census of 110,000 by the end of fiscal year

2007 and 200,000 by the end of fiscal year 2008. VA's teleretinal imaging training center in Boston has trained the necessary image acquisition and reading staff and helps ensure that remote sites can be established and remain viable.

IMPROVING ACCESS THROUGH CBOCs

CBOCs have been the anchor for VHA's efforts to expand access to veterans in rural areas. VHA's CBOCs are complemented by contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area.

VA has continued to improve access to care for veterans in rural areas through a variety of mechanisms. VA outpatient clinics offer rural veterans a full array of primary care services in communities where they live and work. VA has opened 717 new CBOCs since 1995[2]. Of this total, 320 or 45 percent of these are located in rural or highly rural areas. Additionally, there are a number of rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans. Furthermore, there are several additional outpatient clinics that, although located in more populated areas, are positioned to provide care for veterans in the surrounding rural communities. The Fee basis program, authorized under 38 U.S.C. 1703, also provides a local VAMC director with an option in meeting the needs of veterans.

VA's current policy for the planning and activation of CBOCs ensures that new CBOCs meet VA's goal to improve access by current users by placing CBOCs in those areas where users travel significant distances and/or experience excessive travel time to access care.

VA reviews and selects CBOCs through a national approval process based upon the proposals from VA medical centers and the Veterans Integrated Service Networks (VISNs). This process allows decisions regarding needs and priorities to be made in the context of local market circumstances and veterans' preferences.

CBOC proposals are reviewed against national planning criteria including the needs of veterans living in rural areas. The planning criteria include items such as access standards that address veterans living in rural and highly rural areas, as well as additional considerations that include the impact of new CBOCs on waiting times, cost effectiveness, unique demographic or geographic considerations, current workload, quality of care, and enrollment decisions. As noted earlier, CBOC criteria do address unique demographic and geographic concerns such as geographic barriers, low population density, medically underserved or health manpower shortage areas which will enhance care for rural veterans. Criteria points are added for these unique considerations.

[2] Nomenclature clarification: In 1995, the term used for access points was community based or ambulatory clinic. In 2000, Community Based Outpatient Clinic or CBOC became the commonly used term.

VA reviews and revises its policy on the planning and activation of CBOCs annually and new planned CBOCs are centrally integrated into the annual development of resource and budget needs. VA is currently reviewing the CBOC criteria to emphasize those areas of the country that have less than 70 percent of enrollees within drive time standards to access care. (VA Drive Time standards recommend that 70 percent of market enrollees be within 30 minutes of primary care for veterans residing in urban and rural areas, and 60 minutes for those living in highly rural areas). VA will then use this information to develop infrastructure planning and budget needs.

MENTAL HEALTH SERVICES / SPECIAL NEEDS

Comprehensive and effective mental health care is one of the top priorities for VA. The provision of mental health care in rural settings has historically been a challenge for all health systems and providers, including VA.

VA is making changes to address these needs. In fiscal year 2005, VHA began an investment to improve access to mental health services throughout the entire VA health care system, in both rural and urban settings. Resources are funding services that are utilized by veterans living in rural areas, including expansion of Telemental Health programs to provide expert mental health care in rural areas, and providing an innovative rural mental heath intensive case management program (MHICM-RANGE) where the population needing care was not large enough to require a full team.

Some examples of VA's mental health program initiatives that will benefit rural veterans include:

- Integrating specialty mental health care into primary care and other medical settings;
- Continuing to expand access to specialty mental health services at all CBOCs, either by direct staffing, local contracts, or telehealth;
- Developing and piloting a model for rural areas for implementation of the concepts of the Mental Health Intensive Case Management (MHICM) programs; and
- Providing timely access for homeless veterans to mental health/substance abuse assessments.

Performance Measure data indicates that as a result of our intensive efforts to expand services for rural veterans, veterans have access to service much nearer to home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2006, they now live only 13.8 miles away (just half as far).

These and other Performance Measures in Mental Health help to identify success related to the mental health initiatives and to identify areas for continued improvement. In relation to the needs of veterans in rural areas, we are especially committed to expanding Telemental Health resources, to provide the most effective opportunity for enabling even the smallest and most rural of the CBOCs to improve the quantity of their basic mental health care and also to improve access to more specialized mental health services when clinically appropriate.

HOMELESS PROVIDERS GRANT AND PER DIEM (GPD) PROGRAM

VA Homeless Providers Grant and Per Diem (GPD) Program provides grants through a competitive process to community agencies providing services to homeless veterans. The purpose of the program is to promote the development and provision of supportive housing and/or services to help homeless veterans achieve residential stability, increase their skill levels and income, and independence. Efforts are made during funding cycles to award these grants recognizing geographic dispersion. Since GPD's inception, the program has funded more than 75 projects that are in rural locations. It is expected that these grants will support or create over 1,200 transitional housing beds for homeless veterans. Most of the grants were awarded to provide operational funding; however, grants were also awarded to assist in the renovation, acquisition, or construction of buildings to create facilities for the veterans who are homeless.

READJUSTMENT COUNSELING SERVICE / VET CENTERS

The Vet Center program service mission is designed to provide quality readjustment counseling and to remove all unnecessary barriers to care for veterans and family members. The Vet Centers are community-based facilities located at convenient locations within the community to promote ease of access for veterans and family members. All Vet Centers engage in extensive community outreach activities to directly contact and inform area veterans and to maintain active community partnerships with local leaders and service providers to facilitate referrals for veterans in need.

Some Vet Centers are, by plan, established and maintained in rural areas, e.g., Grants Pass, OR; Caribou, ME; Missoula, MT; and Cheyenne, WY, to ensure that rural veterans and families have access to readjustment counseling services. Additionally, we have established Vet Center outstations in rural areas such as Cedar Rapids, IA; the Michigan's Upper Peninsula; and Keams Canyon, AZ on the Hopi Reservation. Outstations are administratively connected to a full sized Vet Center, utilize permanently leased space and are usually staffed by one or two counselors who provide full time services to area veterans on a regular weekly basis. The Vet Centers also maintain some nontraditional hours keeping the Vet Center open after normal business hours or on weekends to accommodate veterans traveling in from greater distances.

Another important aspect of the Vet Center program for maintaining care for veterans in rural areas is to actively establish and maintain partnerships with other community providers such as state employment services, community substance abuse programs and health care providers such as Indian Health Service (IHS). The Vet Center program also maintains a contract program with over 300 private sector providers under contract with VA to deliver readjustment counseling to veterans living at a distance from existing Vet Centers. Some Vet Centers in rural areas have tele-health linkages to their support VAMC which provides veterans in more remote areas access to VA mental health and primary care. The Vet Centers in Santa Fe, NM; Logan, WV; and Chinle, AZ on the Navajo reservation are examples of such sites with active tele-health programs.

Since the onset of hostilities in Afghanistan and Iraq, the Vet Centers have taken a lead role in providing outreach services to returning war veterans. Since 2003 through the first quarter of fiscal year 2007, the Vet Centers have provided services to 165,153 Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans. Following initial contact with Vet Center outreach workers at demobilization sites, many of these veterans disperse home to rural areas of the country. Without the initial Vet Center outreach contact, subsequent access to VA services would be far more of a challenge for many rural veterans.

To further enhance services to the growing numbers of the new generation of returning warriors, VA announced, in February 2007, its plan to expand the Vet Center program. Site selections for new Centers were established based on evidence-based analysis of veteran demographic distributions. In addition, site selection for some of the new Vet Centers was based on special consideration for relatively under-served veterans residing in rural areas at a distance from other VA facilities. There have been 23 new Vet Centers identified to be opened, 8 of them, or approximately 23 percent, are in rural areas. Examples of Vet Centers planned to serve rural veteran populations in rural locations include: Grand Junction, CO; Manhattan, KS; Escanaba, MI; and Watertown, NY.

LTC / NURSING HOMES / DAY HEALTH CARE FACILITIES

The demand for Long-Term Care (LTC), whether in rural or urban settings, has greatly increased due to the aging of the veteran population. VA LTC has evolved from services delivered primarily in geriatric clinics and inpatient nursing home settings to a well-defined spectrum of care, including an array of home and community based care (HCBC) services.

VA believes that LTC services should be provided in the least restrictive setting where services are appropriate to a veteran’s health status, functional status, and personal circumstances, and, whenever possible, in HCBC non-institutional settings. We make every effort to identify options that maximize the veteran's ability to stay within the community for as long as possible. When nursing home care is needed, especially for a veteran residing in a rural area, VA identifies options for the patient from the broad spectrum of LTC venues available in the veteran's community, including the local State Veterans Home or contracted nursing home care. Contracts with rural community nursing homes are maintained so that beds are available when needed by veterans residing in rural areas.

Newer options of VA geriatric healthcare that provide more opportunities for the veteran to stay close to home and family include: 1) Integration of Care Coordination and Home Telehealth into Home Based Primary Care to expand coverage into rural areas; 2) Collaboration with Administration on Aging and Indian Health Service for Home Based Primary Care outreach and caregiver support; 3) Promotion of Hospice-Veteran Partnerships to improve veteran access to community hospice care in rural areas; and 4) development of Medical Foster Home program, where veterans can receive an array

of services including Home Based Primary Care and community hospice care in a supportive home environment in their own community.

COLLABORATIONS

In addition to our internal efforts outlined earlier, VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of health care for rural veterans. We also have partnerships with HHS, including the Indian Health Service and Office of Rural Health providing health care in rural communities. We are also working to establish relationships with other entities, such as with the National Rural Health Association.

CONCLUSION

Mr. Chairman, providing safe, effective, efficient and compassionate health care to our veterans, regardless of where they live, is the primary goal of the VHA. New technologies and better planning are allowing us to provide quality care in any location. VHA recognizes the importance and the challenge of service in rural areas, and we believe our current and planned efforts are addressing these concerns for our current and emerging veterans.

Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.